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ABSTRACT

This study of school-based mental health programs used stakeholder focus groups to examine factors related to positive treatment outcomes, barriers to accessing services, and methods for improving service delivery to high school students with emotional/behavioral disorders. Fifty-one high school students (34 receiving treatment) at three urban high schools participated in eight focus groups. Thirty-eight adults (teachers, therapists, health care staff, and administrators) participated in seven focus groups. Analysis identified themes and categorized them. Categories included: negative aspects of treatment (with the subcategories of therapist characteristics, service delivery issues, and treatment issues); treatment barriers (treatment issues, areas of concern for students, systems issues, political or funding concerns); positive aspects of treatment (including therapist characteristics, therapist role, student ideas, positive results); and suggestions for improving services (education or training, funding issues, political issues, and service delivery). Themes are linked to each category and specific stakeholder group (female students in treatment, male students in treatment, therapists, teachers, administrators, and health center staff). (DB)

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Quality Assurance Activities in High School Student Mental Health Centers

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Introduction

Expanded school mental health (ESMH) programs are becoming increasingly popular systems for providing mental health services for students and families. When mental health services are delivered in schools, there are greater opportunities to reach underserved youth from low-income families (Weist, 1997). If quality assurance (QA) activities are conducted, more information about stakeholder needs and the quality of current programs will be available. QA activities include developing standards, conducting stakeholder focus groups to determine needs and evaluate programs, and implementing Peer Review Teams. Studies that evaluate stakeholder perceptions about mental health services can provide important accountability data by documenting positive and negative aspects related to treatment. For this study stakeholder focus groups were conducted to gain knowledge about the factors related to positive treatment outcome, barriers to accessing services, and methods for improving service delivery for adolescents receiving school-based mental health services.

As a research method, focus groups provide a format for "...individuals to respond in their own words, using their own categorizations and perceived associations" (p. 13, Stewart, & Shamdasani, 1990). Focus groups offer several advantages as a research technique. First, they provide an opportunity to obtain a large amount of data. Second, the researcher is part of the group and can ask questions to understand responses on a deeper level. Third, focus groups allow respondents to build on

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the responses of other group members. Fourth, the results of a focus group are easy to understand and do not require complex statistical analyses (Stewart, & Shamdasani, 1990; Vaughn, Shay, Schumm, & Sinagub, 1996).

Focus groups are a recommended technique for program evaluation, to assess the barriers to and benefits of treatment (Straw & Smith, 1995). We conducted focus groups with different stakeholder groups (e.g., students and teachers) because we were interested in learning more about similarities and differences in their perceptions. Looking at similarities and differences in stakeholder group responses to questions in the aforementioned areas was an important goal of this study. We also wanted to examine a wide variety of suggestions, which is another reason for surveying different stakeholder groups.

Method

Participants

The perceptions of high school students receiving and not receiving mental health services, teachers, therapists, administrators, and health care staff were examined. Participants were recruited at three urban high schools. Most of the students enrolled in these schools were African-American (about 90%) and were from low-income families.

A total of 51 students participated in 8 focus groups. Female students (n = 34) participated in one of 5 groups; 21 were receiving treatment and 13 were not in treatment. Seventeen males participated in 3 groups; 4 were not receiving treatment. Students ranged from 14 to 19 years in age and were in grades 9 through 12, with some seniors who were in their fifth year.

Thirty-eight adults participated in seven groups for teachers, therapists, health care staff, and administrators. Nine adults were males and 29 were females. Teachers, guidance counselors, student advocates, and teachers who were department chairs (n = 15) participated in two groups. Their years of experience in high schools ranged from 1 to 20 years. One group of health care staff was conducted (n= 4); years of experience in school health for staff ranged from 4 to 10 years. Administrators (n=9, including principals and assistant principals) participated in one of two focus groups; experience for this group ranged from 2 to 18 years. Two groups were held for 10 therapists. Therapists were social workers, psychologists, psychology interns, and practicum students. Social workers and psychologists had 1 to 30 years of experience in the field.

Procedure

Focus groups, consisting of participants from each stakeholder group, were conducted to investigate stakeholder perceptions about: ways to improve service delivery, quality of care, treatment outcome (e.g., changes for students, family, school and community), and how to reach more youth in need of therapy. The focus group script was adapted from information presented by Vaughn, Shay-Schumm, and Sinagub (1996).

Group discussions were transcribed and qualitative analyses were conducted to document important themes. Our goal was to develop a customized dictionary of categories for questions, within which relevant themes are presented (see Tables, Stewart, & Shamdasani, 1990). This instrument defines the purpose of the activity (i.e., "to learn how to improve the therapy services delivered at you high school); provides a set of 'rule' to ensure open discussion(e.g., taking turns to speak, respect for each person's opinion, permission to disagree, etc); discussed confidentiality; and provides sample questions for the facilitator.

Results

Findings are presented in Tables 1 through 5. Table 1 presents stakeholder views about the positive aspects of treatment. Females receiving mental health services reported that they preferred a good listener, who is caring, understanding, and respects their confidentiality. Administrators felt positive about successful outcomes related to participating in treatment such as improved coping with family problems. Teacher groups mentioned several issues, among these was the importance of accessibility.

Table 2 presents negative aspects of treatment. Most stakeholder groups thought that missing classes on a regular basis was a drawback. All groups believed that a critical shortage of staff negatively impacts students in that the intensity of treatment that is needed is not always readily available. Several other interesting themes emerged. For example, adolescents value a therapist who does not take notes during sessions. Both teachers and health center staff would prefer to receive more information about the therapy process for students they have referred.

Table 3 presents data about the barriers to obtaining treatment. For instance, all groups mentioned the stigma of "being crazy if one participates in therapy" as a barrier. For females in treatment, concerns that the student's confidentiality would not be maintained were viewed as a barrier to participating in treatment. In the area of funding, the most important issue was the critical shortage of staff (e.g., "one full-time mental health therapist for 1400 students"). This becomes a negative aspect about the program as well as a barrier when therapists can not meet the daily needs, in terms of aiding students in crisis and those in need of therapy.

Table 4 presents stakeholder ideas about ways to improve services. To illustrate, teachers and health center staff thought it would be important to develop advertisements about the benefits of participating in therapy to reduce the impact of the stigma. Again, adding more staff to address the critical shortage of personnel emerged as a key issue for all groups. Therapists believed that if "in-school" rather than "outside-school" suspensions were utilized, it would facilitate their treatment of students with disruptive and oppositional behaviors. They reported that suspending students interrupted treatment and was reinforcing, in that it permitted students who disliked school to stay away. Therapists also felt that they could function more efficiently with administrative support, because writing passes and other paperwork detracts from time that could be spent in clinical practice.

Table 5 documents interesting information about treatment outcomes. For instance, in the academic realm, female students in treatment, administrators, and health center staff endorsed participating in therapy as a method for increasing school attendance and improving grades. As might be expected, all groups believed that participation in treatment was a method for improving self-esteem. Students in treatment (male and female) mentioned that being in therapy improved their attitude. This was a general term for improving their outlook on life and increasing their ability to think positively about challenging life situations. Interestingly, females in treatment thought that being in therapy helped them to avoid peers in the neighborhood who were engaging in risk-taking behaviors (e.g., substance abuse, violent behavior).

Discussion

Results from this study have been useful in providing suggestions for improving services, documenting program strengths, and offering guidelines for enhancing program development. Program strengths included caring therapists, who were accessible, as well as positive results related to participating in treatment (e.g., increased self-esteem,

decreased substance abuse). Examples of negative aspects and barriers included interruptions during sessions, the stigma attached to those who see therapists, and missing classes regularly. Problems typically were associated with the treatment process, therapist behavior, service delivery, and systemic issues (school and funding problems). Some areas for improving services were increasing consumer education, increasing the visibility of the therapist at school, and providing services during the summer. Participating in counseling resulted in many personal changes and some change at other levels: school, peers, family, and neighborhood.

Stakeholder groups did show some consistency in their responses. For instance, stakeholders consistently indicated that more therapists are needed and that there is a critical shortage of therapists in these three schools. Additionally, all groups reported that increased self-esteem typically results from participating in treatment. Moreover, all mentioned that the "stigma of being crazy" associated with treatment impedes student participation in therapy.

On the other hand, inspection of the tables also demonstrated unique response patterns. To illustrate, therapists and administrators may have opposing goals, as administrators want therapists

Table 1
Dislikes: Negative Aspects of Treatment

Categories	Themes	Stakeholder Groups
Therapist Characteristics	Get too personal too fast	STF
	Asking questions student can't answer	STM
	Breaking confidentiality	STM
	Taking notes during session	STF, STM
	Saying "What do you think?"	STF
Service Delivery Issues	Ugly Room	STF
	Interruptions/Lack of Privacy	Ther, STF
	Therapist not on school team	Ther, T
	Too much paperwork	Ther
	Sessions too short	STF
	Need mental health rounds	T, HS
	Increase services for students with behavior problems	A
	Missing classes regularly	STF, STM, Ther, T
	Psychologists are too costly	A
	Shortage of staff	All
Treatment Issues	More focus on internalizing problems	Ther, T
	Refer before crisis point	Ther
	Suspensions	Ther, A
	Attend Special Education Team Meetings	T
	Lack of boundaries around session	Ther
	Stigma of being "crazy"	All
	Therapist not present daily	STF, HS
	Boring	STF
	Staff turnover	STF

Note: Abbreviations for stakeholder groups: female students in treatment (STF), male students in treatment (STM), therapists (Ther), teachers (T), administrators (A), health center staff (HS), and All groups.

to support their decisions about "out-of-school" suspensions, while therapists may argue for "in-school" suspensions. Furthermore, teachers and health center staff may want more information about student progress in therapy than therapists feel comfortable providing to them. Ethical considerations also limit what types and amount of information therapists can share with other professionals.

In summary, results provide accountability data, documenting the positive impact of ESMH programs for high school youth. Increased funding to hire additional staff and provide services during the summer months was cited as a critical need. Participating in school mental health services changed students' lives on many levels. More information is needed about how participating in therapy can change students' lives within their neighborhoods and communities. One shortcoming for this study was that input from males not receiving treatment and parents was not presented. Focus groups are an inexpensive method for evaluating the impact of ESMH programs and allow evaluators to record information about the efficacy of treatment and methods for enhancing the quality of services.

Table 2
Treatment Barriers: Reasons Why Attending Therapy is Difficult for Students

Categories	Themes	Stakeholder Groups
Treatment Issues	Stigma of being "crazy"	All
	Need school-based psychiatry	A
	Therapist not present daily	STF
Areas of Concern for Students	Duty to warn	STF
	Therapist gives bad advice	
	Break confidentiality	SF, STF, A
	Shyness	STF
	Students come late for appointments	STB, Ther
	Students prefer therapist with same ethnicity	Ther, A
Systems Issues	Students don't receive passes	STF, A, Ther, T
	Missing classes regularly	All
Political or Funding	Shortage of staff	All
Concerns	Therapists can't meet daily needs	A

Note: Abbreviations for stakeholder groups are: female students in treatment (STF), male students in treatment (STM), female students (SF), therapists (Ther), teachers (T), administrators (A), health center staff (HS), and All groups.

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Table 3
Likes: Positive Aspects of Treatment

Categories	Themes	Stakeholder Groups
Therapist Characteristics	Pleasant and friendly	SF, STF, T
	Approachable	T
	Good listener	STF, T
	Caring, understanding	STF, A
	Shares information about self	STF
Role of Therapist	Accessible	T
	Confidentiality	STF
	Someone to talk with	SF
Student Ideas	Food	STF
	Get out of going to class; taking tests	STF, STM
Positive Results	Reduce depression	STF
	Cope with family problems	SF, STM, A
	Emotional release	STF, STM, A
	Reduce student-teacher conflict	SF, STF
	Stress reduction	STF, STM, A
	Work through peer conflict	STF
	Increase self-esteem	SF
	Learn problem-solving skills	STM
	Learn assertiveness	STF
	Learn responsibility	SF
	Helps you pass your classes	STF
	Reduce aggressive behavior	SF, STF, STM

Note: Abbreviations for stakeholder groups are: female students in treatment (STF), male students in treatment (STM), female students (SF), teachers (T), and administrators (A).

Table 4
Suggestions for Improving Services

Categories	Themes	Stakeholder Groups
Education or Training	Limits of Confidentiality	Ther
	Need mental health rounds	Ther
	Educate parents about mental health issues	T
	Teen parenting	A
	Substance abuse	A
	Teens who are sexually active	A
	Advertise to reduce stigma	T, HS
Funding Issues	Shortage of staff	A, T, HS, Ther
	Need more office space	Ther
	Advertise; public service announcements	T, HS
	Provide services over the summer	Ther, A
	Therapy available every day	Ther, T
	Hire several therapists, representing all ethnic groups and males and females	Ther
Political	Utilize in-school suspensions	Ther
	Political change resulting in increased funding	Ther
	Enroll all students in health clinic	T
Service Delivery	Administrative support with paperwork	Ther
	Increase service for students with behavioral problems	A
	Involve family in treatment	T
	Protect student confidentiality	Ther
	Increase therapist visibility	Ther
	Support mental health needs of teachers	T

Note: Abbreviations for stakeholder groups are: therapists (Ther), teachers (T), administrators (A), and health center staff (HS).

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Table 5
How Participation in Treatment Changes Students' Lives

Categories	Themes	Stakeholder Groups
Academic Changes	Decrease truancy	Ther
	Increase attendance	STF, A, HS
	Increase grades	STF, S, HS
	Decrease drop-out rate	SF, STF
Personal Changes	Increase self-esteem	All
	Increase social and coping skills	Ther, A
	Improve personal appearance	HS
	Decrease in aggressive behavior	STF
	Increase motivation to do things	STM
	Decrease substance abuse	STF
	Stress Reduction	STF
	Fewer health center visits for medical reasons	HS
	Increase self-worth/new direction in life	SF, Ther
	Become friendlier, more out going	HS
	Improve your "Attitude" (increase positive outlook)	SF, STF, STM
	Develop goals for future	Ther
	Learn to care for own children	STF
Interpersonal Changes	Improve family relations	SF, STF, HS
	Work through peer conflict	SF, STF, STM
	Help with relationships (e.g., boyfriends)	STF
	Reduce student-teacher conflict	STM
Neighborhood Changes	Get along with people in neighborhood	STM
	Avoid negative influences in neighborhood	STF
	Need for therapists to go out into community	SF, STF
Therapist's Role	Emotional outlet	STM, Ther, A
	Connect with trustworthy adult	Ther

Note: Abbreviations for stakeholder groups are: female students in treatment (STF), male students in treatment (STM), therapists (Ther), teachers (T), administrators (A), health center staff (HS), and All groups.

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